DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G190	A. BUILDING _____ B. WING _____	04/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MULTI SERVICES, INC	1008 EVARTS ST, NE WASHINGTON, DC 20018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS Surveyor: 18888 A recertification survey was conducted from April 13, 2010 through April 14, 2010. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a population of four male clients with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and one day program, interviews with clients and staff and the review of clinical and administrative records including incident reports.	W 000	Received 5-12-10 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
W 104	483.41D(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Surveyor: 18888 Based on observation, interview and record review, the governing body failed to implement and ensure it's policy that all controlled substance where stored under double locks, for one of the four clients residing in the facility. (Client #1, #2, #3 and #4) The finding includes: Cross Ref. W381. On April 13, 2010, at 7:40 a.m., the licensed practical nurse (LPN) was observed unlocking a file cabinet that had one lock on it. At 7:55 a.m., the LPN was observed retrieving Clonazepam from the cabinet and administering it to Client #2.	W 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Constance A. Reese TITLE: Program Director (X6) DATE: 5/12/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 Interview with the LPN on April 13, 2010, at approximately 8:20 a.m., after the medication administration revealed the agency's policy indicated that controlled substances (Clonazepam) should be stored under double locks. Review of the agency policy on April 14, 2010, at approximately 9:30 a.m., confirmed the LPN's statement.	W 104	The Primary Nurse will ensure that all medications which are considered controlled medications will be stored under double locks. A separate locked container was purchased and placed in the locked medication cabinet.	4/15/10
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record verification, the facility's qualified mental retardation professional (QMRP) failed to ensure that clients received the recommended GI evaluation, for one of the two clients included in the sample. (Client #1) The finding includes: On April 13, 2010, at 7:43 a.m., Client #1 was observed receiving Ferrous Sulfate 325 mg. Interview with the licensed practical nurse (LPN), after the medication administration indicated that the medication was administered as an iron supplement. Review of Client #1's medical record on April 13, 2010, beginning at 9:53 a.m., revealed a hematology/oncology consult dated June 15,	W 159		

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W 159	Continued From page 2 2009. The consult noted that the client had a diagnosis of "severe iron deficiency amenia". At that time, the hematologist recommended that the client needed a thorough GI evaluation, to exclude GI blood loss, as the etiology. Further review of the client's medical assessment dated July 24, 2009, concurred with the hematologist' recommendation. Interview with the QMRP on April 13, 2010, at 9:35 a.m., revealed that Client #1's family member was active in the clients habilitation and willing to sign medical consents. Further interview indicated that the mother did not want to sign for the aforementioned procedure. According to the QMRP, a medical decision maker would be explored to have a consent signed for the thorough GI evaluation. At the time of the survey, the QMRP failed to ensure that Client #1 received the necessary consent to obtain a thorough GI evaluation, as recommended.	W 159	Client #1 is scheduled for a thorough GI evaluation to exclude GI blood loss on May 25, 2010. A consent form will not be required for the evaluation.	5/25/10
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record	W 249		

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W 249	Continued From page 3 review, the qualified mental retardation professional (QMRP), failed to ensure continuous active treatment, for one of the two clients included in the sample. (Client #1). The finding includes: During the entrance conference on April 13, 2010, beginning at 9:35 a.m., the qualified mental retardation professional (QMRP) indicated that Client #1 received one to one support services. The support is provided to decrease the client's behaviors by using, appropriate/positive procedures and assist with activities of daily living skills. Observations throughout the survey, on April 13 -14, 2010, revealed Client #1 was being physically assisted with his eating, drinking, and tabletop activities. Interview with the one to one support staff on April 13, 2010, at approximately 7:00 p.m., indicated that the client refuses on most of his daily living skills programs. Review of Client #1's Occupational Therapy assessment dated August 12, 2009, on April 13, 2010, at approximately 2:00 p.m., revealed a program objective which stated, "[the client] will apply lotion to his body with stand by assistance on 80% of the trials recorded per month." Review of the individual program plan (IPP) on April 13, 2010, at approximately 2:45 p.m., revealed no evidence of training programs to address the client's training needs.	W 249	The QMRP and House Manager will review all training programs within the IPP to ensure that each objective addresses Client #1 training needs with appropriate documentation.	5/ 31/10
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at	W 255		

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W 255	Continued From page 4 least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observations, staff interviews and record review, the facility's qualified mental retardation professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the client had successfully completed an objective identified in the IPP for one of the two clients in the sample. (Client #2) The finding includes: Observations on April 13, 2010, at 6:30 p.m., revealed direct care staff carrying a laundry basket to Client #2's bedroom. Interview with the staff, at 6:50 p.m., indicated that the client participates in a washing program and requires verbal prompts. Review of Client #2's IPP dated February 22, 2010, revealed a program objective which stated, "[the client]" will improve his independent living skills by being able to wash his clothes with minimal physical assistance, three days a week in 100% of trials." Review of the data sheets, on April 14, 2010, at approximataly 11:45 p.m., from December 2009 through March 2010, revealed the client required verbal prompts to independent 100% of the trials recorded. There was no evidence that the QMRP revised the program (wash his clothes).	W 255	The QMRP will ensure all IPP are revised as needed when the client successfully completes an objective. Client #1's IPP will be revised due to the fact he has accomplished his objective.	5/31/10

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W 325	482.460(a)(3)(iii) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on staff interview and record verification, the facility's nursing staff failed to provide routine laboratory testing as determined necessary by the primary care physician (PCP), for two of the two clients included in the sample. (Clients #1 and #3) The findings include: 1. On April 13, 2010, at 7:43 a.m., Client #1 was observed receiving Tegretol 200 mg. Review of Client #1's medical record on April 13, 2010, beginning at 9:53 a.m., revealed physician's order dated from March 2009, through April 2010, to complete laboratory studies for the following: Tegretol levels, Complete Blood Count (CBC) with differential, Prolactin levels, and Platelets levels every six months. Further review revealed laboratory studies were completed on July 21, 2009. Interview with the registered nurse (RN) on April 13, 2010, and April 14, 2010, at 10:00 a.m., and 12:30 p.m., respectively confirmed that the laboratory studies had not been completed as ordered. 2. Review of Client #2's medical record on April 14, 2010, beginning at 11:00 a.m., revealed	W 325	The Primary Nurse, QMRP, and House Manager will review medical records for Client #2 weekly to ensure that they receive the necessary laboratory testing recommended by the primary care physician.	5/14/10

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W 325	Continued From page 6 physician's order dated from March 2009, through April 2010, to complete laboratory study for prolactin levels every six months. Further review revealed no evidence of prolactin levels. Interview with the registered nurse (RN) on April 14, 2010, at 12:30 p.m., confirmed that the laboratory study had not been completed as ordered.	W 325		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record review, the facility failed to implement an effective system to ensure each client participated in a self-medication program, for two of the two clients included in the sample. (Clients #1 and #2) The findings include: 1. Observation of the morning medication administration on April 13, 2010, at 7:43 a.m., revealed Client #1 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the client's medications from their bubble packs. Continued observation revealed the LPN mixed the client's medication with applesauce and physically spoon fed/administered the client his medications.	W 371	The primary care nurse will complete the proper documentation of self-administration of medications for Client #1 and Client #2, and the self-medication readiness assessment will be updated as needed.	5/14/10

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W 371	Continued From page 7 Interview with the LPN, after the medication pass, revealed the client did not participate in a self-medication training program. Review of the record on April 13, 2010, at 2:27 p.m., revealed a self medication assessment dated November 26, 2009. The assessment indicated that the client was assessed at Skill Level II, which required, "staff assistance/semi-independent" in the area of self-administration of medication. The assessment, however, did not indicate whether or not she was a candidate for self-medication training. Review of Client #1's Individual Program Plan (IPP) dated August 4, 2009, on April 13, 2010, at approximately 3:00 p.m., revealed no program goal or objective for the client to receive training in self-medication skills development. 2. Observation of the morning medication administration on April 13, 2010, at 8:00 a.m., the LPN was observed punching Client #2 medications from the bubble pack into a cup, pouring a cup of water and handing both cups to the client. The client consumed the pills and water independently. Interview with the LPN, after the medication pass, revealed the client did not participate in a self-medication training program. Review of the record on April 14, 2010, at 1:00 p.m., revealed a self medication assessment dated November 26, 2009. The assessment indicated that the client was assessed at Skill Level II, which required, "staff assistance/semi-independent" in the area of self-administration of medication. The assessment, however, did not indicate whether or not he was a candidate for self-medication	W 371		

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W 371	Continued From page 8 training. Review of Client #2's Individual Program Plan (IPP) dated February 22, 2009, on April 14, 2010, at approximately 1:30 p.m., revealed no program goal or objective for the client to receive training in self-medication skills development.	W 371		
W 381	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. This STANDARD is not met as evidenced by: Surveyor: 18886 Based on observation, staff interview and record verification, the facility failed to implement and ensure that controlled substances were stored under double locks, for one of the four clients residing in the facility. The finding includes: On April 13, 2010, at 7:40 a.m., the licensed practical nurse (LPN) was observed unlocking a file cabinet that had one lock on it. At 7:55 a.m., The LPN was observed retrieving Clonazepam from the cabinet and administering it to Client #2. Interview with the LPN on April 13, 2010, at approximately 8:20 a.m., after the medication administration revealed the agency's policy indicated that controlled substances (Clonazepam) should be stored under double locks. Review of the agency policy on April 14, 2010, at approximately 9:30 a.m., confirmed the LPN's	W 381	Cross reference W104	4/15/10

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W 381	Continued From page 9 statement.	W 381		

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Health Regulation Administration

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I 000	INITIAL COMMENTS Surveyor: 18886 A licensure survey was conducted from April 13, 2010, through April 14, 2010. A random sample of two residents was selected from a population of four male residents with various levels of mental retardation and disabilities. The findings of the survey was based on observations at the group home and one day program, interviews with residents and staff and the review of clinical and administrative records including incident reports.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation, the Group Home for the Mentally Retarded (GHMRP) failed to ensure the interior of the GHMRP was maintained in a clean, orderly, attractive, and sanitary manner, for four of the four residents residing in the facility. (Residents #1, #2, #3 and #4) The findings include: An environmental inspection conducted on April 14, 2010, beginning at 2:30 p.m., revealed the following: 1. The dining room overhead light fixture had three of the four bulbs out.	I 090	1. Light bulbs will be replaced in the overhead light fixture.	5/14/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Constance C. Reese TITLE Program Director (X6) DATE 5/12/10

STATE FORM 5X4Q11 If continuation sheet 1 of 10

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I 090	Continued From page 1 2. The pots and pans stored under the kitchen cabinets had food debris and grease on the outside of them. 3. Two pots and/or pans had broken handles on them.	I 090	2. Pots and pans will be thoroughly washed and cleaned daily. QMRP/ Manager will inspect weekly. 3. New pots and pans will be purchased to replace ones with broken handles.	4/15/10 5/20/10
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation and interview, the Group Home for Mentally Retarded Persons (GHMRP) failed to store poisons and caustic agents in a locked cabinet and/or out of direct reach of each resident, for four of the four residents residing in the facility. (Residents #1, #2, #3 and #4) The finding includes: During the environmental walk-thru on April 14, 2010, at beginning at 2:30 p.m., caustic agents (i.e., spray cleaner and bathroom cleaners) were observed being stored in an upstairs closet. The unsecured caustic agents were confirmed with the qualified mental retardation professional (QMRP) on the same day, during the environmental walk-thru.	I 095	The QMRP and House Manager will check daily to ensure that all caustic agents are stored in a locked cabinet at all times.	4/14/10
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at	I 161		

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I 161	Continued From page 2 least annually. This Statute is not met as evidenced by: Surveyor: 18886 Based on interview and record review, the GHMRP failed to provide evidence that the governing body approved and reviewed its policies and procedures annually. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the policy and procedures manual on April 13, 2010, at 1:00 p.m., failed to provide evidence that the policy manual had been reviewed and approved by the governing body as required, since August 28, 2008.	I 161	The QMRP will send the Policy and Procedures Manual to the Main Office to be reviewed and signed by the Program Director annually.	5/31/10
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and... This Statute is not met as evidenced by: Surveyor: 18886 Based on review of the policy and procedures manual, the Group Home for the Mentally Retarded Persons (GHMRP) failed to provide an organizational chart depicting categories and numbers of supportive and direct care staff. The finding includes: Review of the GHMRP's administrative records on April 13, 2010, begining at 1:00 PM, revealed	I 186	The Program Director will revise CMS' Organization Chart to include categories and the number of supportive and direct care staff.	5/31/10

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I 186	Continued From page 3 that the organization chart failed to list the categories and numbers of supportive and direct care staff.	I 186		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Surveyor: 18886 Based on interview and record review, the Group Home for the Mentally Retarded Persons (GHMRP) failed to ensure each staff and consultant had a current health certificate, for five of the ten staff, two of the seven nurses and one of the eleven consultants. The finding includes: Interview with the qualified mental retardation professional (QMRP) and review of the personnel records on April 14, 2010, beginning at approximately 2:30 p.m., revealed the GHMRP failed to provide evidence that current health certificates were on file, for five of the ten staff (Staff #1, #2, #3, #5 and #7), two of the seven nurses (nurse #1, #2, #3, #4 and #5) and one of the eleven consultants (occupational therapist).	I 206	The QMRP and House Manager will request current health certificates from direct care aids, nursing staff, and consultants. Personnel records will be reviewed quarterly for current health certificates.	5/31/10
I 227	3510.5(d) STAFF TRAINING	I 227		

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I 227	Continued From page 4 Each training program shall include, but not be limited to, the following: (d) Emergency procedures including first aid, cardiopulmonary resuscitation (CPR), the Heimlich maneuver, disaster plans and fire evacuation plans; This Statute is not met as evidenced by: Surveyor: 18886 Based on record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to have on file for review, current training in cardiopulmonary resuscitation (CPR), for two of the ten staff and one of the seven nurses, and current training in first aid, for three of the ten staff and five of the seven nurses. The finding includes: Review of the personnel and training records on April 14, 2010, beginning at 2:30 p.m., revealed the GHMRP failed to provide documentation of staff training in CPR, for two of the ten staff (Staff #4 and #5) and one of the seven nurses (Nurse #2), and current training in first aid, for three of the ten staff (Staff #2, #3, and #4) and five of the seven nurses (Nurse #1, #2, #3, #4 and #5).	I 227	The QMRP and House Manager will request that all direct care aids and nursing staff working within the group home have current CPR and first aid training.	5/31/10
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation, interview and record review, the Group Home for the Mentally	I 422		

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I 422	Continued From page 5 Retarded Persons (GHMRP) failed to ensure habilitation, training and assistance were provided to its residents in accordance with their Individual Habilitation Plan(s), for one of the two residents included in the sample. (Resident #1) The finding includes: During the entrance conference on April 13, 2010, beginning at 9:35 a.m., the qualified mental retardation professional (QMRP) indicated that Resident #1 received one to one support services. The support was provided to decrease the resident's behaviors by using, appropriate/positive procedures and assist with activities of daily living skills. Observations throughout the survey, on April 13 -14, 2010, revealed Resident #1 was being physically assisted with his eating, drinking and table top activities. Interview with the one to one support staff on April 13, 2010, at approximately 7:00 p.m., indicated that the resident refused on most of his daily living skills programs. Review of Resident #1's Occupational Therapy assessment dated August 12, 2009, on April 13, 2010, at approximately 2:00 p.m., revealed a program objective which stated, "[the resident] will apply lotion to his body with stand by assistance on 80% of the trials recorded per month." Review of the individual program plan (IPP) on April 13, 2010, at approximately 2:45 p.m., revealed no evidence of training programs to address the resident's training needs.	I 422	Cross reference W249	5/31/10
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months	I 424		

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I 424	Continued From page 6 or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Surveyor: 18886 Based on staff interviews and record review, the Group Home for the Mentally Retarded Persons (GHMRP's) Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident had successfully completed an objective identified in the IPP, for one of the two residents included in the sample. (Resident #2) The finding includes: Observations on April 13, 2010, at 6:30 p.m., direct care staff was observed carrying a laundry basket to Resident #2's bedroom. Interview with the staff, at 6:50 p.m., indicated that the resident participates in a washing program and requires verbal prompts. Review of Resident #2's IPP dated February 22, 2010, revealed a program objective which stated, "[the resident]" will improve his independent living skills by being able to wash his clothes with minimal physical assistance, three days a week in 100% of trials." Review of the data sheets, on April 14, 2010, at approximately 11:45 p.m., from December 2009 through March 2010, revealed the resident required verbal prompts to independent 100% of the trials recorded. There was no evidence that the QMRP revised the program (wash his clothes).	I 424	Cross reference W255	5/31/10

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I 436	Continued From page 7	I 436		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Surveyor: 18886 Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Observation of the morning medication administration on April 13. 2010, at 7:43 a.m., revealed Resident #1 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the resident's medications from their bubble packs. Continued observation revealed the LPN mixed the resident's medication with applesauce and physically spoon fed/administered the client his medications. Interview with the LPN, after the medication pass, revealed that Resident #1 did not participate in a self-medication training program. Review of the record on April 13, 2010, at 2:27 p.m., revealed a self medication assessment dated November 26, 2009. The assessment indicated that the	I 436	Cross reference W371	5/14/10

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I 436	Continued From page 7	I 436		
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Surveyor: 18886 Based on observations, interviews and the review of records, the Group Home for Mentally Retarded Persons (GHMRP) failed to implement an effective system to ensure that each resident participated in a self-medication training program, for two of the two residents in the sample. (Residents #1 and #2) The findings include: 1. Observation of the morning medication administration on April 13. 2010, at 7:43 a.m., revealed Resident #1 was administered his medications by the facility's Licensed Practical Nurse (LPN). The LPN was observed to punch the resident's medications from their bubble packs. Continued observation revealed the LPN mixed the resident's medication with applesauce and physically spoon fed/administered the client his medications. Interview with the LPN, after the medication pass, revealed that Resident #1 did not participate in a self-medication training program. Review of the record on April 13, 2010, at 2:27 p.m., revealed a self medication assessment dated November 26, 2009. The assessment indicated that the	I 436		

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I 436	Continued From page 8 resident was assessed at Skill Level II, which required, "staff assistance/semi-independent" in the area of self-administration of medication. The assessment, however, did not indicate whether or not she was a candidate for self-medication training. Review of Resident #1's Individual Program Plan (IPP) dated August 4, 2009, on April 13, 2010, at approximately 3:00 p.m., revealed no program goal or objective for the resident to receive training in self-medication skills development. 2. Observation of the morning medication administration on April 13. 2010, at 8:00 a.m., the LPN was observed punching Resident #2 medications from the bubble pack, pouring a cup of water and handing both cups to the resident . The resident consumed the pills and water independently. Interview with the LPN, after the medication pass, revealed that Resident #2 did not participate in a self-medication training program. Review of the record on April 14, 2010, at 1:00 p.m., revealed a self medication assessment dated November 26, 2009. The assessment indicated that the resident was assessed at Skill Level II, which required, "staff assistance/semi-independent" in the area of self-administration of medication. The assessment, however, did not indicate whether or not he was a candidate for self-medication training. Review of Resident #2's Individual Program Plan (IPP) dated February 22, 2009, on April 14, 2010, at approximately 1:30 p.m., revealed no program goal or objective for the resident to receive training in self-medication skills development.	I 436		

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I 484	Continued From page 9	I 484		
I 484	3522.11 MEDICATIONS Each GHMRP shall promptly destroy prescribed medication that is discontinued by the physician or has reached the expiration date, or has a worn, illegible, or missing label. This Statute is not met as evidenced by: Surveyor: 18886 Based on observation and record review, the Group Home for Mentally Retarded Persons (GHMRP) nurse failed to remove from use, out dated medications and medications with a worn label, for one of four residents residing in the facility. (Resident #3) The finding includes: On April 14, 2010, beginning at 2:30 p.m., during an environmental inspection, a tube of Tretinoin cream was observed on Resident #3's nightstand. The label on the tube had an expiration date of August 2009. Further observation revealed a tube of Tretinoin cream was in Client #3's nightstand. The label on the tube was worn and could not be read. The qualified mental retardation professional (QMRP), at that time of the inspection, reviewed the label and confirmed that the medications had expired and had a worn label. The QMRP then notified the registered nurse.. At the time of the survey, there was no evidence that the facility's nursing staff ensured that expired medications were removed from the residents' supplies after the expiration date and when the label were worn.	I 484	The Primary Care Nurse, QMRP, and House Manager will check all topical medications weekly to ensure that they are not out-dated and the labels are legible.	5/12/10